

STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

APPLICATION FOR LICENSURE
NATUROPATHIC PHYSICIAN

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents and fees.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure. The fees are for processing your application and will not be refunded. **Please read all instructions carefully.**

Address of Record: The address you provide on this application will be your address of record. All correspondence from DOPL will be sent to that address. You are responsible to directly notify DOPL of any change to your address of record. Do not rely on a forwarding order.

Social Security Number: Your social security number is classified as a private record under the Utah Government Records Access and Management Act. It is used by DOPL as an individual identifier. It is also used for child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements 42 U.S.C. 666(a)(13). If an SSN is not provided, the application is incomplete and may be denied.

SUPPORTING DOCUMENTS AND FEES:

1. Submit an official transcript from a naturopathic medical school or college accredited by the Council of Naturopathic Medical Education, which includes your date of graduation and degree earned.

NOTE: Have the school send the transcript directly to DOPL. You may also have the school send the transcript to you for inclusion with your application so long as it is in a sealed envelope, bearing the school's stamp/seal on the envelope flap.

2. Submit official score results verifying your having passed the Naturopathic Physicians Licensing Examinations (NPLEX). (*See "Additional Important Information" section below.*)

3. Submit one of the following to document meeting the postgraduate residency requirement:
 - ❑ An “Evaluation of Postgraduate Training” form from each of your residency programs to document having successfully completed at least 12 months of postgraduate training in a program associated with an accredited school or college of naturopathic medicine. Request that the Preceptor complete the form and mail it directly to DOPL. Evaluations will not be accepted from administrative personnel. Letters of recommendation will not be accepted in lieu of the evaluation form.
 - ❑ Documentation of at least 6,000 hours of active practice as a naturopathic physician during the five years immediately preceding the date of this application, if applying by endorsement.
4. If applicable, use the “Request for Verification of License” form (*attached to this application*) to obtain verification of licensure from a state in which you have been licensed as naturopath or naturopathic physician.

Request that the verifying state complete the form and mail it directly to DOPL or return them to you for submission with your application.
5. If you are applying for a **temporary license**, additionally submit a “Request for Temporary License to Engage in a Supervised Residency Program” form (*attached to this application*), if you have met all requirements except completing the required residency program.
6. Submit the appropriate non-refundable application-processing fee, payable to “DOPL.”
 - ❑ **\$200.00** for a naturopathic physician license
 - ❑ **\$250.00** for a naturopathic physician **and** a temporary license

ADDITIONAL IMPORTANT INFORMATION:

1. **Utah Laws and Rules:** You are required to understand all Utah laws and rules pertaining to your practice as a naturopathic physician. The following applicable laws and rules are available on the Internet at www.dopl.utah.gov:
 - ❑ Division of Occupational & Professional Licensing Act
 - ❑ General Rules of the Division of Occupational & Professional Licensing
 - ❑ Utah Naturopathic Physician Practice Act
 - ❑ Utah Naturopathic Physician Practice Act Rules
2. **Current Documents:** Applications, statutes, rules, and forms are occasionally changed. Go to www.dopl.utah.gov to ensure you have the most recent version of these documents.
3. **Requirements for Licensure:** All applicants for licensure as a Naturopathic Physician

must meet the requirements as detailed in the Utah Naturopathic Physician Practice Act and Rules. Additional requirements may be found in the Division of Occupational and Professional Licensing Act and Rules. Requirements include **but are not limited** to the following.

- A. An earned degree of doctor of naturopathic medicine from:
 - a naturopathic medical school or college accredited by the Council of Naturopathic Medical Education
 - a naturopathic medical school or college that is a candidate for accreditation by the Council of Naturopathic Medical Education
 - a naturopathic medical school or college which, at the time of the applicant's graduation, met current criteria for accreditation by the Council of Naturopathic Medical Education
- B. After completing the above educational requirement, the successful completion of 12 months of clinical experience in naturopathic medicine in a residency program associated with an accredited school or college of naturopathic medicine under the preceptorship of a licensed naturopathic physician, physician and surgeon, or osteopathic physician.
- C. Pass the licensure series as outlined below.
- D. The ability to read, write, speak, understand, and be understood in the English language.
- E. Meet with the Naturopathic Physicians Licensing Board, if requested.

4. **Requirements for licensure by Endorsement:**

- ☐ Be currently licensed in good standing in another jurisdiction.
- ☐ Have met all the above requirements for licensure except the clinical experience requirement.
- ☐ Have been actively engaged in practice as a naturopathic physician for not less than 6,000 hours during the five years immediately preceding the date of application in Utah.

5. **Examinations:** Applicants must pass the required national examinations.
 - ❑ NPLEX Basic Science Series; OR State of Washington Basic Science Series **OR** the State of Oregon Basic Science Series
 - ❑ NPLEX Clinical Series
 - ❑ NPLEX Homeopathy
 - ❑ NPLEX Minor Surgery
6. **Temporary License:** A temporary license to engage in a supervised residency program may be issued for no more than 18 months to an applicant who has met all the requirements for licensure except completion of a 12-month residency program. The temporary license cannot be renewed or extended. Upon completing the supervised residency program, it is the responsibility of the applicant to submit to DOPL an “Evaluation of Postgraduate Training” form from an approved preceptor documenting successful completion of the residency program. Upon receipt of the documentation, DOPL will issue an active license to practice as a Naturopathic Physician in the State of Utah. The \$250.00 application fee for temporary license includes the fee for the Naturopathic Physician license application. No additional fees are required.
7. **Approved Formulary:** Naturopathic Physicians licensed in the State of Utah after July 1, 1996, are required to limit their prescriptive practice to homeopathic remedies and to the list of legend medications established by rule (R156-71-202). A naturopathic physician may only prescribe those medications which are included in the Formulary, which is available at www.dopl.utah.gov.
8. **Examination Fees:** There are separate fees for all examinations. It is the responsibility of the applicant to submit the fees directly to the testing agency.
9. **License Renewal:** All naturopathic physician licenses expire on May 31 of each even-numbered year.

Unlike many other states, Utah’s license renewal schedule **is not** based on the licensee’s date of initial licensure. Under Utah’s renewal system, all licenses in each profession expire as a group on the same day every two years. Therefore, the length of a licensee’s first renewal cycle depends on how far into the current renewal cycle initial licensure was obtained. Each renewal cycle thereafter is for a full two years.

Additionally, the fee paid with this application for licensure is an application-processing fee only. It does not include a renewal fee. Each licensee is responsible to renew licensure **PRIOR** to the expiration date shown on the current license. Approximately two months prior to the expiration date shown on the license, renewal information is disseminated to each licensee’s last address of record, as provided to DOPL.

10. **Continuing Education:** In order to renew your license you must complete at least 24 hours of approved continuing education.

11. **Updating Address Information:** It is your responsibility to maintain a current address with DOPL. If your address is incorrect, you will not receive renewal notices or other correspondence. Address changes can be made online at www.dopl.utah.gov.
12. **Name Change:** If you have been licensed by DOPL under any other name, please submit documentation of your name change (*i.e. copy of a marriage license or divorce decree*).
13. **Ceremonial Certificate of Licensure:** After obtaining your license from DOPL, you can order a Ceremonial Certificate of Licensure, printed on parchment paper with original signatures and an embossed gold seal. Order forms can be obtained at www.dopl.utah.gov.
14. **Mail Complete Application to:**
 - By U.S. Mail**
Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741
 - By Delivery or Express Mail**
Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111
15. **Telephone Numbers:** (801) 530-6628
(866) 275-3675 – Toll-free in Utah
16. **Fax Number:** (801) 530-6511

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APPLICATION FOR LICENSURE

GENERAL INFORMATION

License(s) Applying For: _____ Naturopathic Physician License
_____ Naturopathic Physician Temporary License

Social Security Number: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Gender: ☐ Male ☐ Female Date of Birth: _____

Have You Ever Held A Utah License Before? ☐ Yes ☐ No

If Yes, Name of Profession: _____

If Yes, License Number: _____

MAILING ADDRESS:

Street: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved: ____/____/____

Approved By: _____

Date License/Certificate Denied: ____/____/____

Denied By: _____

Reason for Denial/Other Comments: _____

NATUROPATHIC MEDICAL SCHOOL: *(Use additional sheets if necessary.)*

Name: _____ Dates Attended: _____ to _____

Location: _____

Degree Received: _____ Date of Graduation: _____

GRADUATE MEDICAL EDUCATION OR TRAINING:

Complete the information below and account for **all** periods of training or postgraduate work from the time you graduated from naturopathic medical school. *(Use additional sheets if necessary.)*

Answer “**yes**” or “**no**.”

_____ I have successfully completed a 12-month residency program associated with a Naturopathic Medical school accredited by the Council of Naturopathic Medical Education.

_____ I am applying for a temporary license to engage in a 12-month residency program associated with a Naturopathic Medical School accredited by the Council of Naturopathic Medical Education.

_____ I have practiced as a licensed naturopathic physician for at least 6,000 hours in the last 5 years preceding the date of this license application.

PROFESSIONAL EXAMINATION REQUIREMENT:

Answer “**yes**” or “**no**.”

_____ NPLEX Basic Science Series, Date(s) Taken: ____/____/____

_____ Washington Basic Science Series, Date(s) Taken: ____/____/____

_____ Oregon Basic Science Series, Date(s) Taken: ____/____/____

_____ NPLEX Clinical Series, Date(s) Taken: ____/____/____

_____ NPLEX Homeopathy, Date(s) Taken: ____/____/____

_____ NPLEX Minor Surgery, Date(s) Taken: ____/____/____

LICENSES: List all licenses, registrations, or certifications issued by any state that you now hold or have ever held in a regulated profession. *(Use additional sheets if necessary.)*

Issuing State: _____ Profession: _____

License Status: _____ License Number: _____ Effective Date: ____/____/____

Issuing State: _____ Profession: _____

License Status: _____ License Number: _____ Effective Date: ____/____/____

POSTGRADUATE RESIDENCY: Account for **all periods** of supervised postgraduate residency program experience associated with a Naturopathic Medical School accredited by the Council of Naturopathic Medical Education. *(Use additional sheets if necessary.)*

1. **Name of Hospital or Treatment Facility:** _____

Address: _____

Department: _____ Telephone: _____

Date Started: ____/____/____ Date Ended: ____/____/____ Total Hours Worked: _____

Name of Supervisor: _____ License Number: _____

Duties and Responsibilities: _____

2. **Name of Hospital or Treatment Facility:** _____

Address: _____

Department: _____ Telephone: _____

Date Started: _____ Date Ended: _____ Total Hours Worked: _____

Name of Supervisor: _____ License Number: _____

Duties and Responsibilities: _____

(Continued on the next page.)

LICENSED PRACTICE: Account for all licensed naturopathic physician experience. You must have at least 6,000 hours in the last 5 years preceding the date of this application, if you are applying by endorsement. (*Attach additional sheets if necessary.*)

1. **Name of Hospital or Treatment Facility:** _____

Address: _____

Department: _____ Telephone: _____

Date Started: _____ Date Ended: _____ Total Hours Worked: _____

Name of Person Who Can Verify Your Licensed Experience: _____

Duties and Responsibilities: _____

2. **Name of Hospital or Treatment Facility:** _____

Address: _____

Department: _____ Telephone: _____

Date Started: _____ Date Ended: _____ Total Hours Worked: _____

Name of Person Who Can Verify Your Licensed Experience: _____

Duties and Responsibilities: _____

AFFIDAVIT FOR UTAH LAWS AND RULES

I understand that it is my responsibility to read and understand all statutes and rules pertaining to my practice as a naturopathic physician in the state of Utah and I agree to comply with such.

Signature of Applicant: _____ Date: _____

NATUROPATHIC PHYSICIAN QUALIFYING QUESTIONNAIRE

Answer “yes” or “no” for each question. Do not leave any question blank.

1. _____ Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
2. _____ Have you ever been denied the right to sit for a licensure examination?
3. _____ Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
4. _____ Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care professional licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
5. _____ Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency or governmental agency?
6. _____ Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
7. _____ Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
8. _____ Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
9. _____ Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
10. _____ Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?

(Continued on the next page.)

11. _____ Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
12. _____ Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
13. _____ Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
14. _____ Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
15. _____ Have you been named as a defendant in a malpractice suit?
16. _____ Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?
17. _____ Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
18. _____ If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
19. _____ Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
20. _____ Have you ever been terminated from a position because of drug use or abuse?
21. _____ Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
22. _____ Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
23. _____ Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other

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applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?

24. _____ Do you currently have any criminal action pending?
25. _____ Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
26. _____ Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
27. _____ Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (i.e. plea in abeyance or deferred sentence)?
28. _____ Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?



If you answered “yes” to questions 24, 25, 26, 27, or 28 above, you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.



If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A “yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

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AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division of Occupational and Professional Licensing in conjunction with this application or its supporting documents meet the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division of Occupational and Professional Licensing or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Applicant: _____

Date of Signature: ____/____/____

Printed Name of Applicant: _____

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EVALUATION OF POSTGRADUATE TRAINING

TO BE COMPLETED BY APPLICANT:

Request that the Preceptor complete this form and mail it directly to DOPL. **Evaluations will not be accepted from administrative personnel. Letters of recommendation will not be accepted in lieu of this form.**

Applicant Name: _____

Applicant Address: _____

City: _____ State: _____ Zip: _____

Name of Evaluating Hospital / Institution: _____

Department: _____ from (Mo/Yr) _____ to (Mo/Yr) _____

Type of Postgraduate Training: ☐ Internship ☐ Residency ☐ Fellowship

I hereby authorize release to the Utah Division of Occupational and Professional Licensing any files, records or information of any type reasonably required for DOPL to properly evaluate my qualifications for licensure as a physician and surgeon.

Applicant Signature: _____ Date: ____/____/____

TO BE COMPLETED BY EVALUATING PHYSICIAN:

Name of Evaluating Physician: *(Please Print.)*

Title: _____ Phone Number: _____

This evaluation is based on: ☐ Personal Knowledge ☐ Review of Credential File

How long have you known the applicant? years: _____ months: _____

Is this training program associated with an accredited naturopathic medical school or college?

☐ Yes ☐ No Name of College: _____

(Continued on the next page.)

Please answer “yes” or “no” for each question. Please do not leave any question blank.

1. _____ Are the dates provided by the applicant on the top portion of the form accurate?
If no, please indicate the period of program: from _____/_____/____ to _____/_____/____
2. _____ Is the applicant related to you?
3. _____ Do you know the applicant well?
4. _____ Has your acquaintance with applicant continued until recent dates?
5. _____ Do you consider the applicant reliable?
6. _____ Do you consider the applicant ethical?
7. _____ Do you consider the applicant to be of good character?
8. _____ Has the applicant, to your knowledge, ever been guilty of fraud or dishonesty?
9. _____ Has the applicant, to your knowledge, ever been guilty of unprofessional conduct?
10. _____ If the English language is not the native language of this applicant, do you feel that he/she has the ability to adequately communicate in the English language?
11. _____ To your knowledge, has the applicant ever been warned, censored, disciplined, had admissions monitored or privileges limited?
12. _____ To your knowledge, has the applicant ever been asked to leave a training or post-graduate program?
13. _____ Did the applicant successfully complete this training program?
14. _____ Do you have any reservations about recommending the applicant for licensure? If yes, please explain on attached sheet.
15. _____ Is there anything else you think we should be aware of in evaluating this applicant for licensure? If yes, please explain on attached sheet.
16. Please rate the applicant's:

Professional Ability:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Adequate	<input type="checkbox"/> Poor
Attention to Duties:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Adequate	<input type="checkbox"/> Poor
Breadth of Education:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Adequate	<input type="checkbox"/> Poor
Interpersonal Skills:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Adequate	<input type="checkbox"/> Poor

All reports received by DOPL on a licensure applicant are confidential and are not subject to disclosure. However, the board must disclose such reports if they are relied upon in a contested denial of licensure.

Evaluating Preceptor's Signature: _____ Date: ____/____/____

Division of Occupational & Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 841114-06741

REQUEST FOR TEMPORARY LICENSE TO ENGAGE IN A SUPERVISED RESIDENCY PROGRAM

TO BE COMPLETED BY THE APPLICANT:

Request that your Residency Supervisor complete this form and return it to you for submission with this application.

Applicant Name: _____

Applicant Address: _____

City: _____ State: _____ Zip: _____

Name of Where Supervision Will Occur: _____

Street Address of Hospital or Facility: _____

City: _____ State: _____ Zip: _____

TO BE COMPLETED BY THE RESIDENCY SUPERVISOR:

Please complete this form and the affidavit and return it to the applicant for submission with his/her application for licensure.

Name of Licensed Supervisor (*please print*): _____

License Classification: ☐ Naturopathic Physician ☐ Physician and Surgeon
 ☐ Osteopathic Physician and Surgeon

Utah License Number: _____ Telephone: _____

Supervisor's Address: _____

City: _____ State: _____ Zip: _____

(Continued on the next page.)

AFFIDAVIT:

I attest under penalty of perjury as follows:

I am the Residency Supervisor of _____. (*Name of Applicant*)

I certify that this residency program is associated with a naturopathic medical school or college accredited by the Council of Naturopathic Medical Education.

I certify that I am responsible to provide direct supervision of the applicant, which means that I am responsible for the naturopathic activities and services performed by the applicant and I will be either in the facility or available by voice communication to direct and control the naturopathic activities and services performed by the applicant.

I certify that I have read and understand the Naturopathic Physician Licensing Act and Rules and that I will insure that the applicant complies with the Naturopathic Law and Rules, and that I will immediately report any violation to DOPL.

I will immediately notify DOPL of any change in status or termination of the residency program.

Signature of Supervisor: _____ Date: _____

Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Fax: (801) 530-6511

REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another state, if applicable.)

TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.

Applicant's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I am requesting licensure in the state of Utah as a: **NATUROPATHIC PHYSICIAN**

I am/have been licensed in your state under the name: _____

My Social Security Number is: _____

My Date of Birth is: ____/____/____

My license number in your state is/was: _____

I have enclosed the necessary license verification fee in the amount of: _____

Signature of Qualifier: _____

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and place the completed form in an envelope, seal the envelope and provide it to the applicant in person or by mail. The qualifier will include the verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee (*as it appears in verifying state's records*): _____

(Continued on the next page.)

Name of Qualifying Person: _____

Classification of License Issued: _____

License Number: _____ Current Status: _____

Original Date of Licensure: ____/____/____ Expiration Date: ____/____/____

Continuously Licensed:

☐ Yes ☐ No, please explain: _____

Licensed By:

☐ Exam, Type: _____ Date: ____/____/____

☐ Endorsement, From What State _____

Examination Scores: _____

Education Required For Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

☐ No ☐ Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____ Title: _____

Agency: _____

Date of Signature: ____/____/____

(SEAL)